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No. 98-2052

IN THE
Supreme Court of the United States

DREW FENTON and KLAUS WAGENER,
Petitioners,

v.

UNIHEALTH AMERICA, INC., *et al.*,
Respondents.

On Petition for Writ of Certiorari to the California Supreme Court

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, CALIFORNIA STATE CHAPTER AND THE AMERICAN COLLEGE OF LEGAL MEDICINE IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE*

The American Academy of Emergency Medicine represents the interests of more than 2500 medical doctors who practice the specialty of emergency medicine. The AAEM was established in 1993 to promote fair and equitable practice environments necessary to allow emergency physicians to deliver the highest quality of patient care. There are, in turn, state chapters of the national organization.

The American Academy of Emergency Medicine, California State Chapter, is an advocate for its physician members concerning emergency medical practice issues in the State of California, the situs of the issue in this petition.

Founded in 1960, The American College of Legal Medicine ("ACLM") is an organization of professionals concerned with issues arising at the convergence of law

and medicine. ACLM's membership consists of approximately 1300 professionals, including physicians and scientists in most specialties, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM is officially recognized by the American Medical Association as the society that represents legal and medical specialists.

The petition in this case presents an issue of vital interest to these *amici* at the national level and at the state level relating to the scope of medical payment reassignments. The California Supreme Court decision in this case undermines the federal law, regulations and policies that Congress intended to create for the payment or reassignment of federal, Medicare benefits.

Therefore, *amici* request this Court to accept the attached brief in support of the petition for certiorari in this case. Petitioners have consented to the filing of this brief, respondents have not consented.

Respectfully submitted,

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QUESTION PRESENTED

Under 42 U.S.C. section 1395u, which limits the assignment of Federal funds earned by physicians who treat Medicare patients, can those physicians assign the public funds due them to a corporation which engages them to work as independent contractors to staff a hospital emergency department?

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INTEREST OF THE *AMICI CURIAE* [1]

The American Academy of Emergency Medicine ("AAEM") is the specialty society of Emergency Medicine. AAEM is a democratic organization of over 2,500 specialists who have achieved certification by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

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1 Petitioners have consented to the filing of this brief, respondents have not consented. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than the *amici curiae* made a monetary contribution to the preparation and submission of this brief.

AAEM, California Chapter, is the local, directly affected state chapter.

The American College of Legal Medicine ("ACLM") is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of physicians, scientists, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys.

The issue at stake in this case is of direct concern to *amici* and their members. *Amici are* deeply committed to fair and equitable practice environments necessary to allow physicians to deliver the highest quality of patient care. *Amici* believes that billing and payment improprieties, in the system of Medicare medical services administered under federal law by the Health Care Financing Administration (HCFA), impede physicians' abilities to provide quality patient care. Therefore, amici's member phsyicians—intended recipients of Medicare benefits payments from HCFA for medical services they provide to patients—have a vital stake in ensuring that the medical reimbursement provisions of the Social Security Act and HCFA's regulations and policies to implement it, are accurately applied and followed, as intended by Congress.

The decision by the California Court of Appeal for the Second Appellate District—that 42 U.S.C. Section 1395u (b)(6) of the federal Social Security Act ("Act") was not violated by *Respondents'* receipt of federal funds due *Petitioners* (review of which was denied by the California Supreme Court)—is an erroneous interpretation of the Act and HCFA's implementing regulations and policies. Left unchanged, the California court decision is an impermissible state interpretation of 42 U.S.C. Section 1395u (b)(6), in violation of Congress' intent.

STATEMENT

Respondent California Medical Center (CMC) is an inner-city hospital primarily serving indigents located in downtown Los Angeles. Pet. App. 2a. Respondent Unihealth is the parent company of CMC. Pet. App. 5a.

The operation of the emergency room at CMC was contracted out to California Emergency Medicine Services (CEMS) a business entity which, in turn, was owned and managed by Respondent Neil Heilpern, M.D. (Heilpern). Pet. App. 2a. Petitioners Drew Fenton, M.D. (Fenton) and Klaus Wagener, M.D. (Wagener) both worked for CEMS in the emergency room of CMC.

Petitioner Wagener had no written contract with CEMS. He was informed by Respondent Heilpern, orally, that he would work in the emergency department at an hourly rate as an independent contractor. The written contract presented by CEMS and signed by Petitioner Fenton, provided that emergency physicians would work at CMC at a stipulated hourly rate as independent contractors. The contracts also provided that all of their billings would be owned by CEMS. Pet. App. 5a.

The federal Medicare statute provisions of the Social Security Act provide in relevant part: "No payment under this part for a service provided to any individual shall . . . be made to anyone other than such individual or . . . other person who provided the service, except that payment may be made to the employer or such physician or other person . . . or (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service . . ." 42 U.S.C. Section 1395u (b)(6)(A)(ii); 42 C.F.R. 424.80(b)(2). Pet. App. 25a.

On appeal, Petitioners contended that the assignment of Medicare funds due them—but required by CEMS to be made to Respondent Heilpern and/or CEMS—was invalid. Petitioners asserted that, by law, the involved Medicare funds can only be paid to them, the doctors who performed the medical services. Thus, the statutory exceptions to the prohibition against fund reassignments to others did not apply ". . . because (a) Fenton was not an employee (therefore the "employer" exception to the prohibition on assignment does not apply), and (b) the funds can only be paid to a professional corporation contracting to provide emergency room services when the services are provided by employee physicians." Pet. App. 24a.

The California Court of Appeal found that Respondent CEMS lawfully received the Medicare reimbursement payments due Petitioners under the Act's exception for "facilities." Pet. App. 25a. Petitioners' Petition for Rehearing and Petitioners' Petition for Review were, respectively, denied by The Supreme Court of California. Pet. App. 2b and Pet. App. 1c.

INTRODUCTION AND SUMMARY OF ARGUMENT

The decision of the California Court of Appeal for the Second Appellate District, as affirmed by The Supreme Court of California ("the California Courts"), erroneously interprets and misapplies the federal Social Security Act's ("Act") stated criteria for the reassignment of Medicare payments.

The "facility" exception—to the Act's prohibition against reassignment of Medicare payments—permits reassignment of Medicare payments to hospitals or other facilities ". . . in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service."

By finding that CEMS may legally receive Medicare payments due Petitioners under the "facilities" exception, the California Courts ignored the fact that CEMS is not a "facility" in which Petitioners' services were provided, as required. Further, the California Courts ignored the fact there were no contractual arrangements between the Petitioner physicians and the hospital (CMC) facility under which CMC, in turn, submitted bills for Petitioners' services, as required.

In addition, the California Court decisions squarely conflict not only with the plain language of the Medicare statute but also with its legislative history, the statute's implementing regulations, applicable provisions of HCFA's Medicare Carriers Manual and subsequent policy statements also promulgated by HCFA—the federal organization which administers the Medicare program and payments.

This Court should restore the scope of the Congressionally-intended exceptions—to the prohibition against reassignment of Medicare payments—as stated in the Act's Medicare statute. Further, this Court should make clear that additional exceptions to the Medicare statute's reassignment prohibition, if any, are the province of the U.S. Congress and HCFA which is charged with the responsibility of implementing the Congress' Medicare directives.

ARGUMENT

I. THE CALIFORNIA COURTS HOLDING CONFLICTS WITH THE SOCIAL SECURITY ACT'S REQUIRED CRITERIA FOR A "FACILITY" TO RECEIVE REASSIGNMENT OF MEDICARE BENEFITS AND MADE NO INQUIRY INTO RECIPIENT CEMS' ELIGIBILITY UNDER THE ACT TO RECEIVE THE MEDICARE BENEFITS DUE PETITIONERS

The "facility" exception to the Social Security Act's prohibition against reassignment of Medicare payments specifically provides that:

> "(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (I) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer; or (ii) (where the service was provided in a *hospital*, critical access hospital, clinic, *or other facility*) to the facility *in which the service was provided* if there is a *contractual arrangement between such physician or other person and such facility* under which *such facility submits the bill for such service. . .*" (emphasis added) (42 U.S.C. Section 1395u(b)(6)(A)(ii).

The plain language of the statute clearly indicates there are three criteria for the facility exception to the prohibition against Medicare payment reassignment: (1) the service must be provided in the hospital or other facility, (2) there must be a contractual arrangement between the physician or other person and the hospital or other facility, and (3) the hospital or other facility must sub-

mit the bill for payment of the service. As stated, the Act's three criteria are interrelated; they work in concert; they do not stand separate and alone.

However, the California Court of Appeal apparently concluded that because Fenton's and Wagener's physician services were indeed provided in a hospital (CMC), the statutory requirements for the "facility" exception to the act's prohibition against Medicare payment reassignments were met. In making this apparent determination, the California Court of Appeal (while disregarding Fenton's and Wagener's request for that court to take judicial notice of applicable interpretive provisions in the Manual of HCFA Division of Benefits Services) declared ". . . we do not see why an agency administering the Medicare funds would adopt a view that is contrary to the plain language of the federal statutes providing such funds may be paid to a care facility." Pet. App. 25a. Yet, the California Courts' conclusion includes no analysis or determination that the Act's criteria for a "facility" exception were actually met by CMC, by CEMS or by Respondent Heilpern.

Amici submits to this Court that HCFA, the agency administering the Medicare funds, has not adopted a view that is contrary to the plain language of the applicable federal statutes. To the contrary, the plain language of the Social Security Act and its Medicare payment provisions are clear. The Act requires a "facility" payment reassignee to meet three interrelated criteria. Yet, the California Court erroneously based its decision only on one of the Act's three interrelated criteria—that the involved physician services were performed in a hospital facility.

The California Court's holding, that meeting one of the Act's criteria for this payment reassignment exception—

performance of the medical services in a hospital facility—satisfies all three required criteria should be rejected for a simple reason: the Act means what it says. In any case of statutory construction, the inquiry begins with the "language of the statute." *Bailey v. United States,* 516 U.S. 137, 144 (1995). Where, as here, "the statutory language provides a clear answer, it ends there as well." *Hughes Aircraft Co. v. Jacobson,* No. 97-1287, slip op. At 5 (U.S. Jan. 25, 1999).

II. THE CALIFORNIA COURTS' HOLDING SQUARELY CONFLICTS NOT ONLY WITH THE PLAIN LANGUAGE OF THE ACT'S MEDICARE STATUTE BUT ALSO WITH THE STATUTES' LEGISLATIVE HISTORY, HCFA'S IMPLEMENTING REGULATIONS AND SUBSEQUENT AND CURRENT HCFA POLICY STATEMENTS AND INTERPRETATIONS

A. The California Courts' Decision Conflicts With the Act's Legislative History

Although the Court's interpretive process need go no further, because the statutory language is straightforward and unambiguous, the legislative history of the Act's Medicare statute supports an ordinary and clear understanding of the need for and Congressional limitations placed on exceptions to the prohibition against the reassignment of Medicare benefits.

Section 1842(b) of the Social Security Act ("Act"), 42 U.S.C. Section 1395u(b)(6), establishes the general principle that Medicare program payments should be made to the beneficiary or, under an assignment, to the physician who provides the physician service. This principle was developed to ensure accountability and to prevent "factoring" (a practice of selling accounts receivable to a third party) that Congress specifically found to be abusive in the payment of Medicare benefits. (See HCFA

Ruling No. 98-1 Date: December 11, 1998, Reassignment of Medicare Benefits, p. 3).

The Act's legislative history demonstrates quite clearly that, by preventing a third party from obtaining payment from the Medicare program, Congress hoped to destroy a third party's incentive to engage in abusive billing practices or to submit claims for services that were not rendered (see March 26, 1997 interpretive letter from HCFA Administrator Bruce Vladeck to Coastal Physician Services, Inc. attached). The HCFA interpretive letter further states that Congressional reports expressly conclude: "Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. . ." H. Rep. No. 92-131, at 104 (1971). *Id.* at 2.

B. The California Court Decision Conflicts With HCFA's Regulations Implementing the Act

HCFA, the federal organization charged with crafting and implementing the regulations to carry out the Medicare payment provisions of the Social Security Act, has correctly concluded that "in light of these (Congressional) findings (to eliminate a third party's incentive to engage in abusive billing practices), our policies have been designed to limit the extent to which Medicare pays individuals or entities that do not directly provide medical case." *Id.* at 2.

Accordingly, HCFA's implementing regulations clearly limit the extent to which Medicare pays individuals or entities that do not directly provide medical care. The HCFA regulations at 42 CFR Section 424.73 entitled "Prohibition of assignment of claims by providers," restates the basic prohibition against reassignments and spe-

cifically lists the agency's exceptions to that prohibition as follows:

"(a) Prohibition. Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payments arrangement.

(b) Exceptions to the prohibition—(1) Payment to a government agency or entity. . . . (2) Payment under assignment established by court order. . . . (3) Payment to an agent. Medicare may pay an agent who furinshes billing and collection services to the provider if the following conditions are met: (1) The agent receives the payment under an agency agreement with the provider; (ii) The agent's compensation is not related in any way to the dollar amounts billed or collected; (iii) The agents compensation is not dependent upon the actual collection of payment; (iv) The agent acts under payment disposition instructions that the provider may modify or revoke at any time; and (v) The agent, in receiving the payment, acts only on behalf of the provider. Payment to an agent will always be made in the name of the provider."

Yet, the California Court in rendering its decision, cites the HCFA implementing regulations but once and, erroneously, does not discuss or analyze the applicability of the HCFA regulations to the issues and parties at all. Instead, the California Court of Appeal characterizes Petitioner Fenton's and Petition Wagener's argument against Medicare payment assignment to Respondent CEMS/Heilpern as a mere attempt ". . . to escape this assignment of funds. . ." Pet. App. 24a.

If the California Court had seriously reviewed and considered the specific requirements for exceptions to prohibition against Medicare payment reassignments stated in

HSFA's implementing regulations, it would have ruled in Petitioner Fenton's and Petitioner Wagener's favor.

C. The California Court Decision Conflicts With HCFA's Interpretive Medicare Program Manual

The HCFA was established in 1972 to administer the federal Medicare program, among others. In the twenty six years since its establishment, HCFA has promulgated a countless number of Medicare interpretive regulations and policy statements. Perhaps none of HCFA's voluminous interpretive statements is more important to the proper determination of the issue posed here than its Medicare Program Manuals, in particular, HCFA's Medicare Carriers Manual Part 3, Chapter III—Claims, Filing, Jurisdiction and Development Procedures ("the Manual").

Section 3060 of the Manual is the daily, practical guide developed and used by HCFA officials to review the propriety of asserted Medicare payment reassignments. In the California Court holding, that court gave scant mention to HCFA's interpretive manuals and only in its subsequent Order Denying Petition for Rehearing and Modifying Opinion, did that court even grant Petitioners' request to take judicial notice of the HCFA Manual cited. Pet. App. 2b.

A momentary review of Section 3060 by the California Court would have led that court to conclude Respondent CEMS/Heilpern does not qualify under HCFA's Manual as a "facility" exception entitled to a reassignment of Petitioners' Medicare benefits payments. Specifically, Section 3060.2—Payment to Facility in Which Services Are Performed—is controlling for this Court's proper review of the issue presented and why this Court should grant Petitioners' Writ of Certiorari.

The Manual's Section 3060.2B—Scope of the Term "Facility"—states: ". . . the term 'facility' is limited for purposes of this rule to institutions which make provision for furinshing services to individuals as inpatients, i.e., hospitals, university medical centers that own and operate hospitals, skilled nursing facilities, nursing homes, the skilled nursing facility or nursing home units of retirement homes, and other institutions of a similar nature. . ." Clearly, this enumeration of included "facilities" does not include a corporation such as CEMS which was owned and operated by Respondent Heilpern for the purpose of providing independent contractor physicians to staff the emergency room at Respondent CMC. Pet. App. 2a.

Further, the Manual's Section 3060.2D—Indirect Contractual Arrangement—provides, in part, that "a contractual arrangement between a physician and a facility in which the phsyician performs services may exist indirectly by reason of a contractual arrangement between the physician and some other entity and a contractual arrangement between that entity and the facility."

Assuming arguendo that the California Court determined (but did not articulate) Petitioners had an "indirect contract" with Respondent facility CMC, its reasoning still remains flawed and would not lead to a judicial conclusion that permits CEMS to receive an assignment of Medicare benefits due Petitioners—the balance of Section 3060.2D still requires the facility (Respondent CMC) to have a direct contractual arrangement with the physician, and the facility ". . . must certify that it will bill and receive payment for the physician's services only so long as it has this direct arrangement." The California Court decision does not mention nor did it inquire about any contractual relationship between Petitioners and Respondent CMC, as required.

The California Court's open disregard if not outright dismissal of HCFA's interpretive Medicare Manuals is no more clear than its failure to review and apply EXAMPLE 2 of Section 3060.2D of the Manual. EXAMPLE 2 provides:

> a professional corporation enters into a contractual arrangement with a hospital to provide physician emergency room services for the hospital and ". . . subcontracts the responsibility for providing the emergency room services to physicians who are independent contractors. *Even though the corporation may not itself bill and receive the payments for the physician services*, the hospital may do so if it enters into direct contractual arrangements with the physicians for this purpose" (emphasis added).

Here, Respondent Heilpern/CEMS subcontracted the responsibility for providing the emergency room services to Petitioners Fenton and Wagener who, under Heilpern/CEMS' contract, are independent contractor physicians, as in EXAMPLE 2. Yet, the California Court decision makes no mention or review of the applicability of the Manual, the Manual's EXAMPLE 2 or the required contractual relationship between Petitioners and Respondent CMC.

Again, the California Court merely concludes that because Petitioners' physician services were performed in a facility hospital (CMC), ". . . we do not see why an agency administering the Medicare funds would adopt a view that is contrary to the plain language of the federal statutes providing such funds may be paid to a care facility." Pet. App. 25a.

D. The California Court Decision Conflicts With Current HCFA Policy Statements

Although the Act's provisions and HCFA's regulations and applicable manual to limit the reassignment of Medi-

care benefits are clear. HCFA continues to restate and reaffirm the Act's limits to reassignments because of the constant need to do so.

In a March 26, 1997 letter from then HCFA Administrator Bruce C. Vladeck to counsel for Coastal Physician Services, Inc., Mr. Vladeck specifically addressed the issue of reassignment of Medicare payments for physician services rendered in hospital emergency rooms.

According to the Administrator's letter, Coastal had a contractual relationship with the involved hospital and a contractual relationship with physicians. There, as here, the contract expressly claimed the physicians are independent contractors, not employees.

In its previous correspondence to HCFA, Coastal requested that HCFA ". . . postpone or modify its policies to enable Coastal to continue to receive Medicare payments for the services provided by contractual physicians within the emergency rooms of various hospitals." Consistent with the Act and HCFA's implementing regulations, Administrator Vladeck responded "we are not able to adopt your suggestion." There, as here, a corporation which staffed hospital emergency rooms sought to expand an exception to the reassignment prohibition.

In Coastal, Administrator Vladeck acknowledged that the Act does contain express exceptions. However, Administrator Vladeck correctly asserted that "exceptions to a statutory prohibition are generally construed narrowly, in order to preserve the intent of the general rule."

As stated in footnoe three of Administrator Vladeck's interpretive policy letter and equally applicable to Petitioners' Writ of Certiorari,

> "this principle is particularly applicable here because the statute specifically restricts the agency's ability

> to make payment. Payments of money from the Federal Treasury are limited to those authorized by statute. *Office of Personnel Management v. Richmond*, 496 U.S. 414, 416 (1990). Indeed, the Court has recognized that the fundamental purpose of the Appropriations Clause of the Constitution "[i]s to assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good, and not according to the favor of Government agents or the individual pleas of litigants." *Richmond*, 496 U.S. at 428. See also, *United States v. MacCollum*, 426 U.S. 317, 321 (1976) ("The established rule is that expenditures of public funds is proper only when authorized by Congress, not that public funds may be expended unless prohibited by Congress").

In addition, HCFA has developed for its and interested parties' use, a written series of "questions and answers" concerning hospital emergency rooms and corporations which attempt to staff hospital emergency rooms with independent contractor physicians.

Apparently unknown to the California Court, the HCFA document is entitled "Question and Answer (Q and A) Document on the Compliance Scenarios Prepared by the Emergency Department Medical Group Industry" ("the document").

Several of the questions posed in the document, and the issue raised by Petitioners' Writ of Certiorari, need to be answered definitively by this Court because the Act, HCFA's implementing regulations and HCFA's interpretive Medicare Manuals are, in many instances, not being followed.

Petitioners' issue is, in part, ". . . can those physicians assign the public funds due them to a corporation which engages them to work as independent contractors to staff a hospital emergency department?"

The twelfth (12) question in the HCFA document, perhaps asks the ultimate question and, in part, answers Petitioners issue as follows:

> "Q. What type of payments and/or billing arrangements are acceptable?
>
> A. In order for HCFA to make payment to an agent, the payment to agent conditions specified in 424.73(b)(3) of the Medicare regulations and in section 3060.10 of the Medicare Carriers Manual (MCM) must be met. For electronic funds transfers, payment must go directly into the physician's bank account. See section 3060.11 of the MCM.
>
> In order for the billing agreement to be acceptable to Medicare, the agreement must ensure that the physician billing records will be available and accessible to the physician on a timely basis. In addition, the billing agent must be paid only by the physician, and can not be compensated by any other third party. HCFA must be assured that the billing agent's sole responsibility is to act on behalf of the physician."

The HCFA focus, unlike the California Court, is on the patient, the payment of public funds for the patient and the payment of public funds to the physician who performs the medical service because the Act requires it to do so. The California Court decision is not based on an all-inclusive understanding of the Act, its requirements and HCFA's regulations and policies which implement the Congressional directives stated in the Act.

Amici urges this Court to grant Petitioners' Petition for Writ of Certiorari in order to decide the issue posed and to make clear that Congress' prohibitions against the assignment of Medicare payments are followed; that the Act's exceptions to these prohibitions are adhered to and that expansion of these exceptions, if any, is the province

of Congress and HCFA, which is charged with the duty to implement Congress' legislative directives and to administer the federal Medicare program.

CONCLUSION

For the reasons stated above, *Amici* requests that Petitioners writ be granted.

Respectfully submitted,

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